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March 31, 2021

To: Humboldt County Board of Supervisors: Supervisors Bohn, Bushnell, Wilson, Bass and Madrone

CC: Connie Beck, Director, DHHS, Humboldt County
Emi Botzler-Rogers, Director, DHHS-MHB Humboldt County
Paul Bugnacki, Assistant Director, DHHS-MHB Humboldt County
Heather Cooper, County Counsel, Humboldt County
Lea Nagy, President, NAMI Humboldt County
Rober Soper MD, Psychiatrist and Chair of BH Committee
Penny Figas, Humboldt-Del Norte Medical Society
Ruby Bayan MD, Psychiatrist and Medical Director of Waterfront Recovery Services
Marek Reavis, Public Defender, Humboldt County
Meagan O'Connell, Supervising Attorney, Conflict Counsel Office
Maggie Fleming, District Attorney, Humboldt County
Kim Bartleson, CEO of Humboldt County Superior Court

RE: Laura's Law and Urgent Need for Crisis-Residential Psychiatric Treatment and Supported Housing

Dear Supervisors,

I am writing to comment on the Board's exploration of the implementation of Laura's Law and the inadequate services in Humboldt county for the most severely ill patients in our community: patients with anosognosia (lack of insight into their illness and need for treatment). As you are likely aware, up to 40% of patients with chronic psychiatric disorders such as schizophrenia, schizoaffective disorder and bipolar disorder have anosognosia and resultant treatment nonadherence in standard outpatient treatment. As you hopefully know, being in a psychotic state is bad for the brain and the longer patients go untreated the higher chance that their illness will worsen, become treatment unresponsive, increase suffering and increase hospitalizations and incarcerations. The **Humboldt County Board of Supervisors** are responsible for the psychiatric treatment that is and is not provided by Humboldt County DHHS, for overseeing how public funds are being utilized and, ultimately, for the human suffering of patients, families and victims as the result of inadequate psychiatric treatment.

As you all are aware, Laura's Law (AB1421) in 2002 and the newer PC1001.36 Pre-Trial MH Diversion Law (AB1810) in 2018 were enacted by the California legislature to provide adequate psychiatric treatment to patients with anosognosia. Laura's Law includes comprehensive Assisted Outpatient Treatment to a subset of patients with severe mental illness and PreTrial MH Diversion allows for eligible patients to receive adequate psychiatric treatment rather than criminal punishment. While Laura's Law did not come with funding, many counties have found funding by shifting resources, obtaining grants and partnering with the state and many counties implemented Laura's Law more than a decade ago. Many counties are using MHSA funds (Prop 63 Millionaire Tax) which the California legislature enacted in 2004 in response to seeing so many deeply troubled

patients on streets due to lack of sufficient treatment. At the state wide DSH Forum on MH Diversion in Sacramento in 2018 one of the presenters was Judge Stephen Manley from Santa Clara county who stated that ALL counties should be using MHSA funding on these patients. The **Humboldt County Board of Supervisors** are responsible for overseeing Humboldt county DHHS's use of MHSA funds. MentalIllnessPolicy.org is an excellent source of information on how some DHHS departments in CA are "working around" the letter (and the spirit) of Prop 63 in order to excuse themselves from adequately treating our most vulnerable mentally ill patients by saying that "The public wants us to spend it on ____" and "We obtained public input". With all due respect, the general public wouldn't know how best to treat severely ill patients but community partners such as consumers, consumer's families, treatment providers and MH administrators would (and should) know. It is my opinion that is is unethical and immoral for the **Board of Supervisors** and DHHS administrators to be spending public funds on non-treatment expenses unless/until adequate treatment is being provided. Some examples include: birthday parties and proclomations for Sempervirens, luxury offices in the Professional Building, parking spaces for administrators, travel and conference expenses for staff who don't provide direct service, private business consultants to analyze why DHHS-MHB is chronically understaffed and then not using the professional input obtained etc.).

While I'm sure it is uncomfortable to contemplate, **EVERY ONE of YOU** is getting paid a **full time salary** (nearly $100,000) (and more for County Counsel and DHHS administrators) to provide adequate psychiatric treatment to our most severely ill patients. I bet you all have comfortable warm homes to return to after your work days and have ample access to food and psychiatric treatment and I believe that ALL people in Humboldt county deserve the same.

I strongly support the implementation of AOT in Humboldt county along with crisis-residential treatment and staffed supported housing. Perhaps Humboldt county could partner with adjacent counties on developing such services. Perhaps a change in leadership of Humboldt county DHHS is in order if the current administrators are unable to provide adequate psychiatric treatment to the very patients that they exist to (and are being paid to) serve. Perhaps the **Board of Supervisors** will want to consider the ongoing and possible future costs to the county of NOT providing adequate psychiatric treatment and supported housing.

Sincerely,

Jennifer Katy Wilson MD

From:	Katy Blue
To:	COB; Bohn, Rex; Bushnell, Michelle; Wilson, Mike; Bass, Virginia; Madrone, Steve
Subject:	Fw: Ending the Criminalization of Mental Illness
Date:	Wednesday, March 31, 2021 12:04:38 PM
Attachments:	lauraslawfactsheet.pdf lauraslawguidetac2009.pdf

Hello Supervisors Bohn, Bushnell, Wilson, Bass and Madrone,

this is a great resource from national NAMI as is NAMI Humboldt. If you are not, I recommend that you all become members.

I will also send you a few resources on AOT/Laura's Law.

You all may be aware of the concerns in Del Norte county that were presented to the DN Board of Supervisors at their meeting last week on 3/23/21 by the CEO of Sutter Health (if not, I recommend you watch the three minute comment beginning at minute 34). You all have likely seen the article about their crisis in Wildrivers Coast blog

Sincerely,

Katy Wilson MD

----- Forwarded Message -----
From: NAMI Newsletter <newsletter@connect.nami.org>
To: "katywblue@yahoo.com" <katywblue@yahoo.com>
Sent: Wednesday, March 31, 2021, 11:24:50 AM PDT
Subject: Ending the Criminalization of Mental Illness

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NAMI recently released "Mental Illness and the Criminal Justice System," a downloadable infographic citing facts about the criminal justice system and its impact on people with mental illness.

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NAMI monitors current research across the field of mental health. On this page, you can find up-to-date information from government organizations, private institutions and academic and industry researchers.

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The NAMI Blog is our way of getting tips, research, information and

messages of hope to you.
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This email was sent by:

NAMI
4301 Wilson Blvd., Suite 300
Arlington, VA, 22203, US

Laura's Law Criminal Justice Fact Sheet[1]

What is Laura's Law?

Laura's Law (also known as Assisted Outpatient Treatment/AOT) is a process that allows courts to compel individuals with severe mental illness and a history of arrest or violence to stay in treatment as a condition for living in the community. Equally important, it commits the mental health system to providing the treatment. Research on AOT programs in other states show they:

- **Keep the public, patients, and law enforcement safer** by reducing physical harm to others (47%); and property destruction (43%).
- **Help the seriously mentally ill** by reducing homelessness (74%); suicide attempts (55%); and substance abuse (48%);
- **Save money** by reducing arrests (83%); incarceration (87%); and hospitalization (77%).

Who is eligible?

It is *only for a very small group* of severely mentally ill revolving door patients well known to law enforcement officers: those with severe mental illness who repeatedly get arrested or hospitalized due to their failure to stay in treatment. Eligible individuals must have a history of non-compliance with treatment that has been a significant factor in being hospitalized or incarcerated at least twice within the last 36 months or resulted in one or more acts, attempts or threats of serious violent behavior within the last 48 months.

Why should LEOs ask Boards of Supervisors to implement Laura's Law?

Laura's Law reduces the number of people entering the criminal justice system and helps ensure those leaving it don't come back. LEOs only step in when one condition has been met: the mentally ill person has been abandoned by the mental health system. At that point, the individuals may be dangerous and are certainly time-consuming. Implementing Laura's Law is formally supported by The California Peace Officers' Association, the California State Sheriffs' Assoc., and various local Police Chiefs because:

- Laura's Law would reduce the 5150, EDP, Suicide and Revolving Door calls that are placing a tremendous time burden on law enforcement resources (*Approximately 250,000 incarcerated individuals in CA have severe mental illness. A person with mental illness in CA is 3.8 times more likely to be incarcerated than hospitalized*).
- Laura's Law would keep LEOs safer. (*LEOs are more likely to be killed by a person with a mental illness [13%] than by assailants who had a prior arrest for assaulting police or resisting arrest [11%]. Nationwide, over 115 LEOs have been killed by people with untreated mental illness. People with mental illnesses killed LEOs at a rate 5.5 times greater than the rest of the population.*)
- Laura's Law can help ensure those released as a result of Brown v. Plata and realignment receive the care they need.
- 1000 homicides a year are attributable to severe mental illness
- Laura's Law could reduce officer-involved shootings of people with mental illness. (*People with severe mental illnesses are killed by police in justifiable homicides at a rate nearly four times greater than the general public. These incidents also create friction between police departments and the communities as recent events in CA show.*)
- Laura's Law returns treatment of people with severe mental illness back to the mental health system *(20% of San Mateo jail population has a serious mental illness).*
- Laura's Law saves criminal justice money (*When NV County implemented Laura's Law, 521 days of pre-AOT incarcerations fell to just 17 days post-AOT–a 97% reduction in incarceration days. With the cost amounting to approximately $150 per day, the cost savings in this small county from decreased incarcerations amounted to $75,600.)*

Does Laura's Law work?

New York City introduced Kendra's Law (the model for Laura's Law) over fifteen years ago. Because of its success, it was taken statewide over ten years ago. A study in *Psychiatric Services* found *the odds of arrest for a violent offense were 8.61 times greater before participants entered Kendra's Law than after.*

> "(B)oth the general public and people (in AOT) benefit—the former through a reduction in crime and violence and the latter through a reduction in experienced coercion and all of its untoward consequences."

Nevada County, CA found Laura's Law reduced use of incarceration 97% (504 days); and hospitalization 61% (pre and post AOT).

Why is Laura's Law needed?

There is a small group of people with severe mental illness who are so ill, they don't believe anything is wrong with them ("anosognosia"). For example, they don't "believe" they are Jesus, or the FBI planted a transmitter in their head--they "know" it. A subset of this group rejects treatment, then experiences hallucinations and delusions and becomes needlessly homeless, hospitalized, arrested, incarcerated, dangerous or suicidal. 5150 interventions *require* dangerous behavior. Laura's Law *prevents* it. It is the only community-based program for individuals with mental illness *who refuse treatment.*

Why hasn't Laura's Law been implemented in each county?

California is far behind the rest of the nation. Similar laws exist in 42 states. Counties may implement it only after the Board of Supervisors passes a resolution (enc.) to do so. Mental Health Departments have not recommended it to supervisors, perhaps because they fear it would require them to prioritize the most severely ill–those who refuse treatment. Supervisors could implement it based on the recommendation of the law enforcement communities, but so far law enforcement officials have failed to communicate their support or the resolution to the supervisors.

Is Laura's Law is expensive?

No. Laura's Law does not provide any services individuals are not already entitled to. It does help ensure the mental health system gives the severely ill the same services they offer others who are less ill. Incremental costs are the relatively small court costs to ensure individuals receive due process protections and these are offset by savings in arrest, trial, incarceration, and parole for the criminal justice system; and reductions in hospitalizations for the mental health system. Nevada County saved $1.81 for every dollar invested including $346,950 of hospitalization costs. Judge Tom Anderson is a big supporter.

Where will the money come from?

Voters passed Prop 63/Mental Health Services Act (MHSA) specifically to provide funding for "severe mental illness". The county mental health departments have accepted this funding, but not the requirement to spend it on the most severely ill. California DMH ruled MHSA funds can be used for patients regardless of whether they have voluntary or involuntary status but some mental health officials are reluctant to do so. Nevada and LA Counties do fund their Laura's Law programs with MHSA funding. They supplement it with private insurance, Medicaid, Medi-Cal, and patient fees. It is also possible that Sec. 118 funds can be used.

Prepared by Mental Illness Policy Org http://lauras-law.org

1. Sources for quoted studies and facts can be found at http://mentalillnesspolicy.org

A Guide to Laura's Law

California's Law for Assisted Outpatient Treatment

Third Edition, September 2009

Prepared by

The California Treatment Advocacy Coalition &

The Treatment Advocacy Center

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I – How & Why Assisted Outpatient Treatment Came to California

Randall Hagar, Charles Sosebee & Carla Jacobs
Coordinators, California Treatment Advocacy Coalition

The California Treatment Advocacy Coalition formed in 1999. Bringing us together were lives lost to severe mental illnesses – lives of people in jail or prison, people mired on the streets, people who killed themselves – because of laws that withhold treatment for treatable conditions.

At first we were only a handful. With shared passions and the support of the Treatment Advocacy Center, we soon became an advocacy cadre with hundreds of consumers, family members, and mental health professionals visiting legislators, writing letters to politicians and newspapers, and stomping the halls of the Capitol.

And always in the name of treatment.

The law has been among treatment's worst enemies in California. Passed over 30 years ago, the Lanterman-Petris-Short Act ("LPS") governs interventions of needed care for people overcome by psychiatric disorders. It takes no account of what has since been learned about these illnesses, the vastly different present framework of mental health services, or the diversity of effective medications that are now available.

Under LPS, people in California rendered incapable of making rational decisions - no matter how psychotic or delusional - must be an immediate danger to themselves or others before being placed in treatment. Even when they are permitted, moreover, interventions are essentially limited to short inpatient stays. As a result, LPS has come to champion the "right" to be sick over the right to be well.

The members of CTAC rallied behind the indomitable Assemblywoman Helen Thomson's efforts to reform our state's archaic treatment laws. And after three years, a failed original bill, nine committee votes, four floor votes, and the last quest for a governor's signature – CTAC's crusaders helped bring about the most significant reform of California's treatment law in more than three decades when Governor Gray Davis signed Assemblywoman Thomson's Assembly Bill 1421 into law.

Fashioned after New York's proven Kendra's Law, AB 1421 (also know as "Laura's Law) makes assisted outpatient treatment available in California. Assisted outpatient treatment's sustained and intensive court-mandated care in the community now can help those most overcome by the symptoms of a severe mental illness. The treatment mechanism is used until a person is well enough to again maintain his or her own treatment regimen. And eligibility for assisted outpatient treatment is not predicated solely on dangerousness. A progressive eligibility standard allows programs created under AB 1421 to help people who are vitally in need of care but who do not meet LPS' restrictive dangerousness threshold for inpatient hospitalization.

As a bridge to recovery, assisted outpatient treatment can stop the "revolving door" of

repeated hospitalizations, jailings, and homelessness. Yet while thousands of Californians can now receive essential treatment because AB 1421 is law, this is in no way guaranteed. Assisted outpatient treatment is only available in those counties that establish programs for this new treatment option.

The bulk of this guide describes how assisted outpatient treatment works and how it can be used to bring care for someone overwhelmed by a severe psychiatric disorder. The last section is about how, should it not have this critical treatment mechanism, you can help secure assisted outpatient treatment for your community.

A law unused might as well have never been passed. We urge you to find out if your county has assisted outpatient treatment. If it does not, we ask you to write, call, or visit and make your county mental health director and board of supervisors know that it should.

AB 1421 creates for many, where none existed before, the chance for help and maximum possible recovery. It is up to you to make use of this avenue to treatment and, if need be, help make it available to those in your county who most suffer because of mental illness.

II – Overview

What is assisted outpatient treatment?

Assisted outpatient treatment is sustained and intensive court-ordered treatment in the community for those most overcome by the symptoms of severe mental illness. The treatment mechanism is only used until a person is well enough to maintain his or her own treatment regimen. Serving as a bridge to recovery for those released from inpatient facilities as well as an alternative to hospitalization, assisted outpatient treatment can stop the "revolving door" of repeated hospitalizations, jailings, and homelessness.

Is assisted outpatient treatment for all people with mental illness?

Absolutely not. Assisted outpatient treatment (AOT) is for those who are in a crisis or recovering from a crisis caused by mental illness and for whom voluntary services are not working. California's program is based on that of Kendra's Law, a statewide assisted outpatient treatment program created in New York in 1999 that has proven extraordinarily successful. In New York State, Kendra's Law is used to help approximately one thousand people each year.

Does assisted outpatient treatment work?

Yes, spectacularly so. The best studies of AOT show that it drastically reduces

rehospitalizations, length of hospital stays, arrests, victimization, and violent behavior. The outcome numbers available for Kendra's Law have been equally favorable and dramatic, particularly in the areas of treatment adherence, usage of mental health services, and reducing homelessness.

Where is assisted outpatient treatment available in California?

Assisted outpatient treatment is available in those counties that have a program for the treatment mechanism and in which the county board of supervisors has passed a resolution authorizing its use. Some counties may choose to establish a separate program for AOT, while others may integrate its use into existing ones that already provide intensive services.

Call your county's mental health department to find out if it has an assisted outpatient treatment program. If your county does not have AOT, please pay special attention to the last section of this guide and learn how to secure this vital treatment mechanism for those in your area who most suffer from severe mental illness.

III – How Assisted Outpatient Treatment Works

What are the eligibility criteria for assisted outpatient treatment?

A person may be placed in assisted outpatient treatment only if, after a hearing, a court finds that all of the following have been met. The person must:

1) Be eighteen years of age or older;
2) Be suffering from a mental illness;
3) Be unlikely to survive safely in the community without supervision, based on a clinical determination;
4) Have a history of non-compliance with treatment that has either:
   A. Been a significant factor in his or her being in a hospital, prison or jail at least twice within the last thirty-six months; or
   B. Resulted in one or more acts, attempts or threats of serious violent behavior toward self or others within the last forty-eight months;
5) Have been offered an opportunity to voluntarily participate in a treatment plan by the local mental health department but continue to fail to engage in treatment;
6) Be substantially deteriorating;
7) Be, in view of his or her treatment history and current behavior, in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would likely result in the person meeting California's inpatient commitment standard, which is being:
   A. A serious risk of harm to himself or herself or others; or
   B. Gravely disabled (in immediate physical danger because unable to meet

basic needs for food, clothing, or shelter);

8) Be likely to benefit from assisted outpatient treatment; and
9) Participation in the assisted outpatient program is the least restrictive placement necessary to ensure the person's recovery and stability.

Any time spent in a hospital or jail immediately prior to the filing of the petition does not count towards either the 36 or 48-month time limits in criterion No. 4 above. In other words, if an individual spent the two months prior to the filing in a hospital, the court can then look back 38 months (36+2) to see if he or she meets criterion No. 4(A).

Who can petition the court for assisted outpatient treatment?

Only the county mental health director, or his or her designee, may file a petition with the superior court in the county where the person is present or reasonably believed to be present. The following persons, however, may request that the county health department investigate whether to file a petition for the treatment of an individual:

1) Any adult with whom the person resides;
2) An adult parent, spouse, sibling, or child of the person;
3) If the person is an inpatient, the hospital director;
4) The director of a program providing mental health services to the person and in whose institution the person resides;
5) A treating or supervising licensed mental health treatment provider; or
6) The person's parole or probation officer.

On receiving a request from a person in one of the classes above, the county mental health director is required to conduct an investigation. The director, however, shall only file a petition if he or she determines that it is likely that all the necessary elements for an AOT petition can be proven by clear and convincing evidence.

What has to be in or included with the petition?

The petition must state: (1) that the person is present or believed to be present within the county where the petition is filed; (2) all the criteria necessary for placement in AOT; and (3) the facts supporting the belief that the person meets all the criteria.

The petition must be accompanied by an affidavit of a licensed mental health treatment provider stating that either:

1) The licensed mental health treatment provider examined the person no more than ten days prior to the submission of the petition, recommends assisted outpatient treatment, and is willing to testify at the hearing; or
2) The licensed mental health treatment provider, or his or her designee, made appropriate attempts no more than ten days prior to the filing of the petition to examine the person and the person refused as well as that the licensed mental health treatment provider has reason to suspect the person meets the criteria for

assisted outpatient treatment and he or she is willing to examine the person and testify at the hearing.

How long after the filing is the hearing on the petition?

The court must fix a date for a hearing on the petition that is no more than five days (excluding weekends and holidays) after it is filed.

Continuances will only be allowed for good cause. Before granting one, the court shall consider the need for an examination by a physician and the need to provide assisted outpatient treatment expeditiously.

Who has to be notified when you file a petition?

The petitioner must cause a copy of the petition and notice of the hearing to be personally served on the person who is its subject. The petitioner also has to send notice of the hearing and a copy of the petition to:

1) The county office of patient rights; and
2) The current health care provider appointed for the person, if known.

Note: The person subject to a petition may also designate other people to receive adequate notice of the hearings.

Is the person subject to the petition represented by counsel?

The person who is subject to the petition has the right to be represented by counsel at all stages of an AOT court proceeding. If the person elects, the court shall immediately appoint a public defender or other attorney to oppose the petition. If able to afford it, the person is responsible for the cost of the legal representation on his or her behalf.

What is a settlement agreement and how does it affect assisted outpatient treatment?

After an AOT petition is filed but before the conclusion of the hearing on it, the person who is the subject of the petition may waive the right to a hearing and enter into a settlement agreement. If the court approves it, a settlement agreement has the same force and effect as a court order for assisted outpatient treatment, including in the case of non-compliance.

The settlement agreement must be in writing, agreed to by all parties and the court and may not exceed 180 days (note – initial orders by a court after a hearing are for a period of up to six months, which can be a few days longer). The agreement is conditioned upon an examining licensed mental health treatment provider stating that the person can

survive safely in the community. It also must include a treatment plan developed by the community-based program that will provide services to the person.

After entering a settlement agreement, a court designates the appropriate county department to monitor the person's treatment under, and compliance with, the settlement agreement. Only the court can modify settlement agreements, but either party may request a modification at any time during the 180-day period.

What happens at the first hearing?

The court will hear testimony and, if advisable, examine the person (in or out of court). The testimony need not be limited to the facts included in the petition.

If the person fails to appear at the hearing and appropriate attempts to elicit attendance have failed, the court may conduct the hearing in the person's absence. However, the court is prohibited from ordering AOT unless a physician who has personally examined the person no more than ten days before the filing of the petition testifies in person at the hearing.

If the person is present at the hearing but has refused and continues to refuse to be examined and the court finds reasonable cause to believe the allegations in the petition to be true, it may order the person be taken into custody and transported to a hospital for examination by a licensed mental health treatment provider. Absent the use of the inpatient hospitalization provisions of California law, the person may be kept at the hospital for no more than 72 hours.

Any person ordered to undergo assisted outpatient treatment who was not present at the hearing at which the order was issued may immediately petition the court for a writ of habeas corpus, which is a judicial challenge asserting, under these circumstances, that the person does not meet the eligibility criteria for AOT. Treatment under the order may not commence until that petition is resolved in another hearing.

What kinds of decisions can the court make?

If after hearing all relevant evidence, the court finds that the person does not meet the criteria for assisted outpatient treatment, the court will dismiss the petition.

If the court finds, by clear and convincing evidence, that the person meets the criteria for assisted outpatient treatment and there is no appropriate and feasible less restrictive alternative, the court may order the person to receive assisted outpatient treatment for up to six months.

How is the treatment plan developed?

In the assisted outpatient treatment order, the court shall specify the services that the person is to receive. The court may not require any treatment that is not included in the proposed treatment plan submitted by the examining licensed mental health treatment provider. The court, in consultation with the county mental health director, must also find the following:

1) That the ordered services are available from the county or a provider approved by the county for the duration of the court order;
2) That the ordered services have been offered on a voluntary basis to the person by the local director of mental health, or his or her designee, and the person has refused or failed to engage in treatment;
3) That all of the elements of the petition have been met; and
4) That the treatment plan incorporated in the order will be delivered to the county director of mental health, or his or her appropriate designee.

How can the assisted outpatient treatment order be renewed?

If the condition of the person requires an additional period of AOT, the director of the assisted outpatient treatment program may apply to the court prior to the initial order's expiration for an additional period of AOT of no more than 180 days (initial orders are for a period of up to six months, which can be a few days longer). The procedures and requirements for obtaining a renewal order are the same as for obtaining an initial order.

Can a person be released early from an assisted outpatient treatment order?

There are two methods by which someone under an order can establish that he or she no longer meets the eligibility criteria and should be released from an AOT order:

1) No less than every 60 days the director of the assisted outpatient treatment program is required to file an affidavit with the court stating that the person still meets the criteria for placement in the program. Although not explicitly stated in the statute, this presumably means that anyone who does not meet the criteria must be released from AOT. The person has the right to a hearing to challenge the assessment. If the court finds that the person does not meet the criteria, it will void the AOT order.
2) Also, an assisted outpatient may at any time file a petition for a writ of habeas corpus. At the hearing on this petition the court will determine whether or not the person still meets the initial AOT eligibility requirements. If not, the person shall be released from the AOT order.

In either type of hearing the burden of proving that the AOT criteria are still met is on the director.

What if a person fails to comply with an assisted outpatient treatment order?

A licensed mental health treatment provider can request that one of certain designated classes of persons (peace officers, evaluation facility attending staff, members of mobile crisis teams, and other professional persons designated by the county) take a person under an AOT order to a hospital to be held for an up to 72 hours to determine if he or she meets the criteria for inpatient hospitalization (*i.e.,* that the person is a danger to self/others or gravely disabled because of a mental illness).

The treatment provider may only make such a request on determining that:

1) The person has failed or refused to comply with the court-ordered treatment,
2) Efforts were made to solicit compliance, and
3) The person may need involuntary admission to a hospital for evaluation.

Any continued involuntary retention in the evaluating facility beyond the initial 72 hours must be pursuant to the California Code's provisions for inpatient hospitalization. A person found not to meet the standard for involuntary inpatient hospitalization during the evaluation period and who does not agree to stay in the hospital voluntarily must be released.

Failure to comply with an order of assisted outpatient treatment alone is not sufficient grounds for involuntary civil commitment. Neither may such non-compliance result in a finding of contempt of court.

What rights and protections do persons subject to the petition have?

A person subject to a petition for assisted outpatient treatment has the right to:

1) Retain counsel or utilize the services of a court-appointed public defender;
2) Adequate notice of the hearings;
3) Have notice of hearings sent to parties designated by the person;
4) Receive a copy of the court-ordered evaluation;
5) Present evidence, call witnesses and cross-examine adverse witnesses;
6) Be informed of his or her right to judicial review by habeas corpus;
7) Not be involuntarily committed or held in contempt of court solely for failure to comply with a treatment order;
8) Be present at the hearing, unless he or she waives this right;
9) Appeal decisions and be informed of his or her right to appeal; and
10) Receive the least restrictive treatment deemed appropriate and feasible.

IV – Getting Assisted Outpatient Treatment For Your County

What can I do to help obtain assisted outpatient treatment for my county?

You should strive to persuade the people who determine mental health policy in your county that not only is AOT needed, but that it will work. Since they must pass a resolution adopting AOT, the ultimate decision lies with the members of your county's board of supervisors. We urge you to write, call, and/or meet with them. And the more you coordinate your efforts with others in the pursuit of this treatment-ensuring program, the more your efforts will be amplified.

In order to bring AOT to your county, you should seek out assistance from other individuals and organizations interested in securing care for people with severe psychiatric disorders. Contacts, and especially visits, from representatives of groups like NAMI, police, sheriffs, judges, correctional officials, and mental health professionals should be particularly effective in getting the message out to the members of the board of supervisors of your county.

As the elected leaders of counties rely on them for advice on mental health policy, you should also promote assisted outpatient treatment with the director of your county mental health department and the members of your local mental health board. You will be playing into an interesting dynamic. The director is the expert but the members of the board of supervisors are collectively his or her bosses. And the board members, as elected officials, are accountable to you, the registered voter.

What types of services must a county provide to establish an assisted outpatient treatment program?

Any county that elects to establish an assisted outpatient treatment program must have available for those placed in the program a threshold of services that, among others, includes:

1) Community-based, mobile, multidisciplinary, highly trained mental health teams that have staff-to-client ratios of no more than one team member per ten clients under AOT orders;
2) A service planning and delivery process that includes provisions to:
    A. Determine the numbers of persons to be served, and the programs and services that will be provided to meet their needs;
    B. Plan for outreach to families, psychiatric and psychological services, coordination and access to medications, substance abuse services, housing assistance, vocational rehabilitation, and veterans' services;
    C. Provide staff who can remove barriers to services resulting from cultural, linguistic, racial, age, and gender differences;

D. Offer services to older adults, persons who are physically disabled and seriously mentally ill young adults (25 years of age or younger) who are at risk of becoming homeless; and
E. Provide housing that is either immediate, transitional, permanent, or all of these.

3) Personal service coordinators, who may be part of the AOT program team, who are responsible for ensuring, to the extent feasible, that people subject to assisted outpatient treatment receive services which enable them to:
   A. Live in the least restrictive housing feasible in the local community;
   B. Engage in the highest level of productive activities appropriate to their abilities and experience;
   C. Access appropriate education and vocational training;
   D. Obtain an income;
   E. Exert as much control over their lives as possible;
   F. Access physical health care; and
   G. Reduce antisocial or criminal behavior.

Will these assisted outpatient treatment services be more than my county is willing to provide?

Most, if not all, of the components of the service and delivery process in the second section above should already be part of most county mental health systems and would only have to be used by the AOT team. The personal service coordinators and the objectives outlined in the third section can be integrated into any high-intensity service program, like one for assisted outpatient treatment. Furthermore, the objectives of those coordinators must only be met "to the extent feasible," which makes them far less than absolute requirements. The service requirements for AOT are the same as those provided by most counties under their existing MHSA (Mental Health Service Act) programs. Those services must be provided without discrimination as to legal status and thus people requiring AOT can be served by using MHSA funding.

The primary obstacle to a county establishing an AOT program is that it must have an intensive treatment team with a high staff to client ratio, which is described in the first section above. There are three basic manners in which a county can satisfy this requirement.

1) Create a team dedicated solely to the care of people in AOT. This solution would allow your county to make the greatest use of the AOT program authorized by Assembly Bill 1421.
2) Integrate assisted outpatient treatment into existing programs that meet the threshold requirements. Many counties already have programs that meet or substantially meet the service requirements, such as programs for assertive community treatment or intensive homeless outreach programs. Even if counties

with these in place are not willing to establish specifically dedicated AOT teams, these programs can – often with little modification – meet the requirements for and make use of AB 1421.

3) Designate a team from existing county mental health professionals. AB 1421 does not require that every member of the team must be dedicated full-time to the care of those in assisted outpatient treatment. Any group of county-designated mental health professionals can qualify as an AOT team so long as the staff to client ratio is no more than one to ten (an average of approximately four hours total staff time per client), the team is mobile (at least some of the team members can reach clients in the community), and the team can provide the level and types of services mandated by the statute. Thus a personal services coordinator and a psychiatrist on an AOT team would not have to work together on a daily basis. They would only need to be part of a team that provides the necessary AOT services. Otherwise, the AOT team members could work with other clients and in other programs. Using this approach, even the smallest county can make use of assisted outpatient treatment.

Will my county have to offer increased voluntary services if it offers assisted outpatient treatment?

Provisions of the authorizing legislation, AB 1421, require that any county providing assisted outpatient treatment must also offer the same services on a voluntary basis. These services are provided through most MHSA programs. This does not require that everyone asking for those services be provided with them.

What it does mean is that intensive services, such as those in an AOT program, cannot be reserved exclusively for those under AOT orders. Rather, voluntary patients must have access – with distribution prioritized on the basis of need – to the same services offered by AOT treatment teams or to equivalent ones offered in programs not dedicated to assisted outpatient treatment. AB 1421 thus guarantees that those with the greatest need can take a place in line for the best available community services regardless of whether or not they are subject to court-ordered treatment.

Can my county create an assisted outpatient treatment program out of its existing mental health budget?

In order to create an AOT program a county's board must make a finding that no voluntary mental health program will be reduced as a result of implementing an AOT program.. As it is targeted at helping those prone to multiple hospitalizations, repetitive jailings, suicide, and violence – AOT is more appealing to most elected officials than a typical mental health program. County boards should be interested in funding such a politically attractive program.

An assisted outpatient treatment program can also, however, be justified on the basis of its cost-effectiveness. AOT substantially reduces the single greatest expense to any mental health system, that of inpatient hospital days. Based on those savings alone, a county board of supervisors could make the finding that voluntary services will not be affected. Moreover, those placed in AOT will, for the most part, be people who are continually – if sporadically – already under the care of the mental health system. The cost of much of their care will thus be a shifting of costs rather than an increase.

What has proven the effectiveness of assisted outpatient treatment?

The Duke Studies are the largest and most respected of the controlled examinations of assisted outpatient treatment. Among the released findings of this one-year randomized trial:

1) **AOT Reduces Hospitalizations**
   Assisted outpatient treatment for 6 months or more combined with routine outpatient services (3 or more outpatient visits per month) decreased hospital admissions by 57% and the average length of hospital stays by 20 days.[1]

2) **AOT Reduces Arrests**
   For a subgroup with a history of multiple hospitalizations as well as prior arrests and/or violent behavior, the re-arrest rate of those in AOT for 6 months or more was one-quarter (12% versus 47%) that of those who were not under treatment orders.[2]

3) **AOT Reduces Violence**
   Assisted outpatient treatment of 6 months or more combined with routine outpatient services reduced the incidence of violence in half (24% versus 48%).[3]

4) **AOT Reduces Victimization**

   Over one year, 42% of those in the control group were victims of crimes, such as rape, theft, mugging, or burglary versus only 24% of those who were in AOT for 6 months or more with routine services: AOT decreased victimization by 43%.[4]

The outcome numbers from the law on which California's assisted outpatient treatment is based are equally conclusive. A comprehensive independent evaluation conducted for New York found that assisted outpatient treatment for people with severe mental illness is effective in a wide-range of measures, and provides long-lasting benefits the longer someone with a mental illness is in the program:

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[1] Swartz, M.S., Swanson, J.W., Wagner, R.H., et al: Can involuntary outpatient commitment reduce hospital recidivism? *American Journal of Psychiatry*, 156:1968-1975 (1999).

[2] Swanson, J.W., Swartz, M.S., Borum, R., et al: Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. *British Journal of Psychiatry*, 176: 224–231 (2000).

[3] Swanson, J.W., Swartz, M.S., Borum, R., et al: Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. *British Journal of Psychiatry*, 176: 224–231 (2000).

[4] Hiday V.A., Swartz. M.S., Swanson J.W. et al: Impact of outpatient commitment on victimization of people with severe mental illness. *American Journal of Psychiatry, 159*: 1403-1411 (2002).

- Hospitalizations were reduced by more than one-half among people receiving 12 months or more of assisted outpatient treatment.
- The likelihood of arrest in any given month was reduced from 3.7 to 1.9 percent for AOT participants as compared to before they were in the program.
- Suicide or other attempts of people on assisted outpatient treatment to harm themselves decreased by more than half;
- Non-adherence to medications among participants decreased from 47% to 33% after six months of AOT.[5]

What can I do to get more information about getting assisted outpatient treatment for my county?

The Treatment Advocacy Center can answer questions about AOT, supply you with additional materials on the treatment mechanism, as well as help you join the California Treatment Advocacy Coalition, a group of advocates that led the movement for legislation authorizing assisted outpatient treatment in California, and who are now at the forefront of the effort to secure its adoption in the counties.

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[5] New York State Assisted Outpatient Treatment Program Evaluation at www.macarthur.virginia.edu/aot_finalreport.pdf

Prepared as a public service by the

TREATMENT ADVOCACY CENTER

This Guide and other materials on AB 1421 can be found at:

www.treatmentadvocacycenter.org

The Treatment Advocacy Center is a nonprofit organization dedicated to eliminating barriers to timely and humane treatment for the millions of Americans with severe brain disorders, such as schizophrenia and manic-depression (bipolar disorder). Current federal and state policies hinder treatment for psychiatrically ill individuals who are most at risk for homelessness, arrest, or suicide. As a result, an estimated 2.2 million individuals with severe mental illnesses are not being treated for their illness at any given time. The Center serves as a catalyst to achieve proper balance in judicial, legislative, and policy decisions that affect the lives of people with serious brain disorders.

CONTACT INFORMATION

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